Illinois Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6008239	A. BUILDING: _____ B. WING _____	07/07/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
REGENCY CARE	2120 WEST WASHINGTON SPRINGFIELD, IL 62702

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S 000	Initial Comments MDS 3.0 Focus and Staffing Survey	S 000		
S9999	Final Observations Statement of Licensure Violation: 300.610a) 300.1210b) 300.1210d)5) 300.1220b)3) 300.3240a) Section 300.610 Resident Care Policies a) The facility shall have written policies and procedures governing all services provided by the facility. The written policies and procedures shall be formulated by a Resident Care Policy Committee consisting of at least the administrator, the advisory physician or the medical advisory committee, and representatives of nursing and other services in the facility. The policies shall comply with the Act and this Part. The written policies shall be followed in operating the facility and shall be reviewed at least annually by this committee, documented by written, signed and dated minutes of the meeting. Section 300.1210 General Requirements for Nursing and Personal Care b) The facility shall provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychological well-being of the resident, in accordance with each resident's comprehensive resident care plan. Adequate and properly supervised nursing care and personal care shall be provided to each resident to meet the total nursing and personal care needs of the resident. d) Pursuant to subsection (a), general nursing	S9999	Attachment A Statement of Licensure Violations	

Illinois Department of Public Health
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE 07/28/16

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care shall include, at a minimum, the following and shall be practiced on a 24-hour, seven-day-a-week basis:
5) A regular program to prevent and treat pressure sores, heat rashes or other skin breakdown shall be practiced on a 24-hour, seven-day-a-week basis so that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that the pressure sores were unavoidable. A resident having pressure sores shall receive treatment and services to promote healing, prevent infection, and prevent new pressure sores from developing.
Section 300.1220 Supervision of Nursing Services
b) The DON shall supervise and oversee the nursing services of the facility, including:
3) Developing an up-to-date resident care plan for each resident based on the resident's comprehensive assessment, individual needs and goals to be accomplished, physician's orders, and personal care and nursing needs. Personnel, representing other services such as nursing, activities, dietary, and such other modalities as are ordered by the physician, shall be involved in the preparation of the resident care plan. The plan shall be in writing and shall be reviewed and modified in keeping with the care needed as indicated by the resident's condition. The plan shall be reviewed at least every three months.
Section 300.3240 Abuse and Neglect
a) An owner, licensee, administrator, employee or agent of a facility shall not abuse or neglect a resident. (Section 2-107 of the Act)

These requirements are not met as evidenced by:

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Based on observation, interview, and record review the facility failed to accurately assess a resident's risk for the development of pressure ulcers and failed to prevent the development of a stage 3 and a stage 4 pressure ulcer for one of two residents (R4) reviewed for pressure ulcers in a sample of ten.

Findings include:

A Wound & Ulcer Policy and Procedure dated 3/31/14 states, "It is the policy of this facility to provide nursing standards for assessment, prevention, treatment, and protocols to manage residents at any level of risk for skin breakdown and for wound management...All residents will be assessed to determine the degree of risk of developing a pressure ulcer...Residents with existing ulcers will be scored at high risk automatically...Specialty mattress (low air loss, alternating pressure, etc. (etcetera) with enhanced pressure reducing/relieving properties may be placed on the resident's bed...Approaches will be placed in the resident's care plan...Care intervention for staff involved in the resident's care are communicated via the resident's care plan...When an existing or newly developed pressure ulcer(s) is present, a skin assessment ("skin check") will be documented each shift to monitor the individual resident's tolerance to the current repositioning schedule..."

An Ulcer Definitions policy dated 3/31/16 states, "A pressure ulcer is localized injury to the skin and/or underlying tissue usually over a bony prominence, as a result of pressure, or pressure in combination with shear..."

R4's Ulcer/Wound Documentation sheet dated 5/24/16 documents that R4 had four unstageable

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pressure ulcers at the time of admission 5/21/16. R4's pressure ulcers were located on the right heel, right great toe, right outer bunion, and right outer foot.

R4's Skin Risk Assessment (Braden) records dated 5/21/16 and 5/28/16 document R4 is at moderate risk for developing pressure ulcers. R4's Skin Risk Assessment (Braden) records dated 6/4/16 and 6/11/16 document R4 is at low risk for developing pressure ulcers. And R4's Skin Risk Assessment (Braden) record dated 7/4/16 documents R4 is at moderate risk for developing pressure ulcers.

R4's Minimum Data Set (MDS) assessment dated 5/26/16 documents R4 is severely cognitively impaired, requires extensive assistance from one person for bed mobility and hygiene, and extensive assistance of two people for transfers and toileting. R4's MDS also documents R4 is frequently incontinent, and has impairment to one lower extremity.

R4's care plan dated 5/31/16 states, "Do not reposition R4 during hours of sleep." R4's care plan does not include instructions for when to turn and reposition R4.

R4's nurse's note dated 6/15/16 documents R4 developed two new wounds, " Below R4's right side of the buttock, a 1cm x 1cm (centimeter) open sore was found. Also a 2cm x 2cm open area was found on the right side of buttock." The nurse's note documents that a specialized pressure reducing mattress was requested for R4.

R4's Ulcer/Wound Documentation sheet dated 6/21/15 documents R4's right buttock wound was

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initially identified 6/21/16 as an unstageable pressure ulcer measuring 7.0cm x 4.0cm with necrotic tissue (eschar) covering the wound bed. The wound sheet also documents R4's right ischium wound was also initially identified on 6/21/16 as an unstageable pressure ulcer.measuring 0.5cm x 0.6cm with eschar covering the wound bed.

R4's Wound Care Specialist (Z1)Evaluation dated 6/28/16 documents R4's right ischium wound was no longer unstageable but was a stage 3 pressure ulcer. Z1's evaluation also documents R4's right buttock wound remained unstageable but had deteriorated.

R4's Wound Care Specialist Evaluation dated 7/5/16 documents R4's right buttock wound was no longer an unstageable pressure ulcer but was now a stage 4 pressure ulcer measuring 5.0cm x 4.0cm x 0.5cm with undermining along the lower border of the wound.

On 7/6/16 at 9:15a.m. E5 (Wound Nurse) was changing R4's right buttock pressure ulcer dressing. E5 removed the old dressing then cleansed the area before reapplying a clean dressing. R4's wound was a large round area approximately 5.0cm long x 4.0cm wide x 0.5cm deep and with tunneling noted to the lower edge of the wound. E5 stated R4's facility acquired pressure ulcers to the right ischium and right buttocks developed on 6/21/16 when the facility did not turn and reposition R4 at night.

On 7/6/16 at 12:35p.m. E5 stated that E5 has documented on R4's Skin Risk Assessment (Braden) record to determine R4's risk for pressure ulcer. E5 stated that E5 did not know R4 should have automatically been considered as

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high risk for developing pressure ulcers since R4 had pressure ulcers present at the time of admission.

On 7/7/16 at 8:55a.m. E5 stated that E5 adds interventions to R4's plan of care for pressure ulcer prevention. E5 stated R4 was supposed to be on an every two hour turning and repositioning program after developing pressure ulcers to the right ischium and buttock. E5 verified R4's care plan for care and treatment of R4's pressure ulcers does not include any information about turning and repositioning.

On 7/7/16 at 10:15a.m. E2 (Director Of Nurses) stated that when R4 was admitted to the facility R4 was given a regular mattress. E2 stated that on 6/15/16 when R4 developed the pressure ulcers to the right ischium and buttock, R4 was then switched to a specialized pressure relieving mattress.

On 7/6/16 at 11:20a.m. Z1 (Wound Care Specialist) stated that R4's pressure ulcers were caused from unrelieved pressure. Z1 stated R4's pressure ulcers to the right ischium and right buttock "definitely" could have been caused by the facility not turning and repositioning R4 at night.

(B)